National Center for Healthy Housing

State and Local Childhood Lead Poisoning Prevention Programs:
The Impact of Federal Public Health Funding Cuts

Prepared by the National Center for Healthy Housing
July 2013

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Summary of Results

Key Findings

- As of June 2013, it is estimated that 96.5 (57%) of the 170 *state* Childhood Lead Poisoning Prevention Program positions funded by The U.S. Centers for Disease Control and Prevention (CDC) grants have been either eliminated or shifted to other duties due to federal budget cuts that began in FY12. The magnitude of impact, especially among local subgrantees and contractors, will continue to emerge as states grapple with the full effects of sustained federal budget cuts.
- Staff in positions lost due to budget cuts include those assigned to mission-critical activities such as:
  - — Primary prevention of lead poisoning;
  - — Environmental lead risk assessments and healthy home assessments in the homes of children with lead exposure;
  - — Enforcement of state and local laws that require homes to be made lead-safe;
  - — Outreach and education to a variety of public and professional audiences (including parents and physicians); and
  - — Tracking of at-risk children (surveillance).
- The loss of the safety net provided by this vital public health work force is a serious concern for state and local program administrators.
- States and local programs are competing for alternative sources of funding and reimbursement for these services, with varying degrees of success.
- Medicaid reimbursement for eligible case management and follow up services is inconsistent and inadequate in most states and localities.

Methodology

The National Center for Healthy Housing (NCHH) conducted an online survey between May 15 and July 9, 2013, to gauge the impact of the loss of CDC funding on Childhood Lead Poisoning Prevention Programs. A total of 36 responses were received. Five responses were excluded because they either had a high number of missing responses (>50%) AND lacked identifying information (missing responses for both the location and type of program) or represented a duplicate response for a state. The remaining 31 responses were categorized as State CLPPPs or as other subgrantees/local programs.

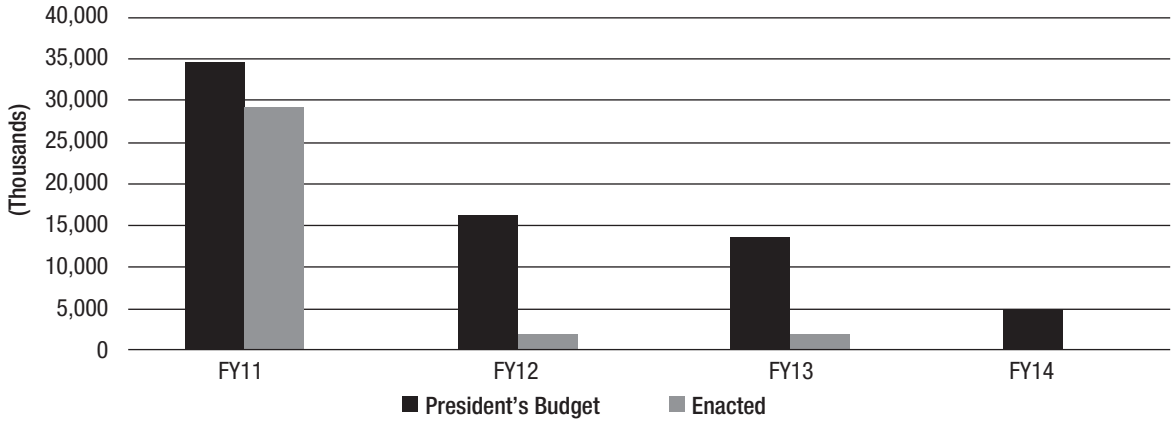
The analysis presented is based on responses from a total of 22 state programs (21 states and the District of Columbia[1]) out of a possible respondent pool of 35 programs (63% response rate). In addition, nine local program administrators responded. A map showing the distribution of responses appears as Appendix 1. Given the distribution of funds through states to local health departments, the total universe of local programs and staff are unknown.

Background

Congress reduced the budget for the U.S. Centers for Disease Control and Prevention (CDC) Healthy Homes and Childhood Lead Poisoning Prevention Program from $29 million in FY11 to $2 million in FY12, effectively eliminating grants to state and local health departments for lead poisoning prevention. This significant cut was carried forward in FY13 due to the federal government operating under a continuing resolution (see Figure 1.) After more than two decades of supporting state and local health department efforts to prevent childhood lead poisoning, CDC is no longer able to support these state and local efforts. This survey is intended to quantify the impacts of those cuts on essential staff, mission-critical services, overall surveillance, and the public health of communities served by programs all over the country.

[1] *State program administrators responded from CT, DC, GA, FL, IL, IA, KY, LA, MA, ME, MN, MS, NH, NJ, NY, NC, OH, OK, OR, RI, VT and WA. Local program administrators responded from ME, NV, NM, NY, NC, PA, TX, and VA.*

Figure 1: CDC's Healthy Homes/Lead Poisoning Prevention Program Budget Snapshot



Results

1. Positions eliminated or shifted

Respondents report widespread, significant reductions in staff and services with the potential for negative public health impacts. Among the 22 state programs responding, 15 (68%) reported that at least one position was eliminated and/or shifted to other duties. These program changes impacted a total of 60.5 positions or an average of 4.0 per state (among states reporting a loss of at least one position).

- Responding states eliminated a total 37.5 FTEs and shifted 23 FTEs.
- A total of 96.5 (57%) of the 170 CDC-funded positions in State programs will have been impacted to date, assuming the same pattern among the 13 CLPPP states that have yet to respond[2].
- Local health departments either eliminated or shifted 1.4 positions on average.[3]

As shown in Table 1, positions were lost or shifted across the entire scope of activities including home environmental lead risk assessments and healthy home assessments, enforcement of regulations to require that homes be made lead-safe, outreach and education to a variety of audiences (including families and health care providers), the tracking (surveillance) of at-risk children, record keeping, administrative duties, and more.

2. Program Components Eliminated

With so many positions lost, it is important to understand the scope of services that are no longer available to the public. Half of state administrators and 56% of local programs reported a loss of critical program components.

Outreach and Education to Families and Providers

Most notable is the reported loss in outreach and education programming to key vulnerable populations, (such as pregnant women), the public at large (families and community members etc.), professionals (healthcare providers, real estate agents, property managers, etc.), as well as in primary prevention activities.

To provide additional context for these losses in terms of service impacts, NCHH asked respondents how many individuals would no longer receive educational presentations or materials. The responses showed significant reductions in numbers of people served and contacts made through the programs.

[2] *Assuming that 68% of the remaining 13 state CLPPPs (or roughly 9 states) have shifted or eliminated an average of 4.0 positions.*

[3] *At this time data are not available regarding the total number of local subgrantee staff paid through CDC funds.*

Table 1: Positions Eliminated or Shifted[4] Among Programs Reporting Loss of At Least One Position

Position[5]	STATE CLPPPs (n=15) Eliminated	STATE CLPPPs (n=15) Shifted	LOCAL PROGRAMS (n=4) Eliminated	LOCAL PROGRAMS (n=4) Shifted
Environmental Health Professional	33%	27%	0%	50%
Health Educator	33%	33%	25%	25%
Case Manager	27%	40%	0%	50%
Other*	27%	40%	0%	50%
Surveillance/Data Management	13%	40%	25%	25%
Program Coordinator	13%	47%	25%	25%

**Other: clerical staff/support staff/ administrative assistants/data entry personnel.*

- For example, one local program will no longer be able to serve approximately 500 families and will reduce contact with physicians from 127,000 per year to zero.
- Another stopped all brochure production, previously about 100,000 per year, referring all information requests to their website. For high risk and low-income populations, conveying information through the internet may be less effective than through printed materials at the appropriate reading level and translated into multiple languages.

Responses also show how program administrators had to make compromises, such as by reducing nurse consultation, restricting offers of education only to families of children who test at high blood levels (e.g. ≥10 µg/dL), or limiting distribution of materials by health departments to health care providers.

In CDC's response to its 2012 federal advisory committee report entitled, *"Low Level Lead Exposure Harms Children: A Renewed Call of Primary Prevention,"* it stated:

> *"Clinicians should monitor the health status of all children with a confirmed BLL ≥5 µg/dL for subsequent increase or decrease in BLL until all recommended environmental investigations and mitigation strategies are complete, and should notify the family of all affected children of BLL test results in a timely and appropriate manner."*

Without health department education of clinicians, the above guidance is unlikely to be received or implemented by health care providers.

Primary Prevention

> *"…childhood lead poisoning prevention programs (CLPPPs) must initiate and collaborate with other groups and agencies in implementing housing-based primary prevention strategies that work at the community level."*
>
> CDC Advisory Committee On Childhood Lead Poisoning Prevention

CDC's Advisory Committee strongly recommends primary prevention—a recommendation that many respondents expressed concern about not being able to implement. Primary prevention goes beyond education to the enactment and enforcement of policies, especially housing related, to truly prevent exposures to hazards. The Advisory Committee describes eight elements of a comprehensive program for primary prevention of childhood lead poisoning and charges state and local programs with a leadership role in primary prevention.

[4] Proportions reported in the table are the proportion of programs reporting elimination or shifting of one or more of these types of positions and does not necessarily reflect the actual counts of positions lost (e.g., 33% of state programs reported losing at least one environmental health professional, but the actual proportion of eliminated/shifted staff that are environmental health professionals is not known).

[5] A description of specific job duties may be found in Appendix 2.

However, when asked which primary-prevention activities would be impacted in response to budgetary pressures, respondents indicated partial or complete elimination of education and outreach, even to the families of at-risk children, and to contractors who might create lead hazards through renovation work. One program eliminated outreach to pregnant women and another no longer coordinates efforts with community service providers.

Case Management and Environmental Testing of Homes

Eighteen percent of state respondents reported the elimination of case managment services (Table 2.) Although no local program reported the complete elimination of case management, environmental investigations, or blood lead screening; significant reductions were noted. Few respondents are able to offer families services for blood lead levels at CDC's new reference value (see Table 3). Five of 20 state programs reported providing no services to this population.

The new lower value means that more children will likely be identified as having lead exposure allowing parents, doctors, public health officials, and communities to take action earlier to reduce the child's future exposure to lead.[6]

- One state reported 1/3 fewer investigations.
- Another state reported a reduction of about 200 investigations per year.

[6] *http://www.cdc.gov/nceh/lead/ACCLPP/blood_lead_levels.htm*

Table 2: Program Components Eliminated Among Programs with At Least One Eliminated Component

Component Eliminated	State (n=11)	Local (n=5)
Education/Outreach to the General Public	73%	80%
Education/Outreach to Professionals	73%	60%
Primary Prevention activities	55%	40%
Nurse Consultation for Case Management	18%	0%
Surveillance Activities	9%	20%
Environmental Investigations	9%	0%
Renovation, Repair and Painting Rule Activities	9%	20%
Screening	0%	0%

Table 3: Services Provided for Children with Blood Lead Levels between 5–9 µg/dL

State Strategies (N=20)		Local Strategies (N=9)	
Mail education	45%	Phone education	67%
Phone education	40%	Mail education	56%
Other	30%	No services	44%
No services are provided to this population	25%	Education by partner agency	22%
Education by partner agency	20%	Inspection of home	11%
Inspection of home	20%	In person education	11%
In person education	15%	Inspection by partner agency	11%
Inspection by partner agency	10%	Other	0%

- A third state program can only do basic investigation but can no longer do healthy home assessments (thus eliminating a more comprehensive approach of reducing injury and other hazards during a home visit).
- At the local level, nearly half of the respondents indicated no follow-up services. This means that parents are not informed of blood lead test results, children are not retested, and parent don't know to take any action. Inspections only happen 11% of the time locally.

Strategies to address the loss of case management capabilities included the continuation of service in some counties but not others, the provision of services only for very high lead levels (e.g., ≥20µg/dL), and simply severely curtailing the scope of assistance provided to local public health agencies.

Comments from the survey indicate an undesirable variability in services provided to those who test at 5–9 µg/dL:

- "This varies by local health department."
- "Varies by local health department and is dependent on staffing levels."
- "We do the above as time and resources allow. Usually we send a letter, and if the family calls, we will advise." (Emphasis added)
- "We will provide educational information…if requested."
- "We offer grant money to grantees who respond to 5–9, but only with a doctor referral....We would not be able to respond to all 5–9 on top of our current case load with the personnel we have available at this time."
- "Will begin to offer free lead dust tests to venous BLLs between 5 and 9 if funding allows."

Surveillance

Cuts mean some states can no longer report blood lead data to CDC or pursue proven primary prevention strategies. And, although surveillance, investigations, and case management components appear to be largely intact now, future funding for many programs beyond 2014 is uncertain.

Other Programming and Service Reductions or Losses

Renovation, Repair, and Painting (RRP) trainings were often funded by EPA or HUD. One local program curtailed RRP activities and now offers the training for a fee. Other losses include:

- The elimination of a GIS project that provided risk-based maps and consulted with communities across the state;
- The termination of a contract with staff who conducted healthy home assessments, and therefore:
  - — No education about smoke and CO detectors
  - — No distribution of child safety kits
  - — No referrals to funding sources for assistance to correct hazards

3. Replacement Funding

Along with the elimination and shifting of positions and the elimination and curtailment of program components, states and local organizations are competing for other source of funding with varying degrees of success.

Local programs show much less resiliency in their funding with two-thirds reporting no new funding. Nine state programs (45%) were able to rely on the cushion of past funding versus only 11% of local programs. Both state and local programs reported new sources of funding, but not consistently.

Table 4: Alternative Funding of Program Components that were funded by CDC

Funding	State(n=22)	Local(n=9)
Through funding in place before CDC cuts	45%	11%
Through new funding source	36%	22%
No new funding	18%	67%

As they cobble their programs and resources together, here are some of the alternative strategies employed, in order of frequency of responses:

- Appropriation of state funding
- CDC Environmental Public Health Tracking Program[7]
- Medicaid
- Maternal and Child Health
  - — Block Grant
  - — Maternal, Infant, and Early Childhood Home Visiting formula and competitive grant
  - — Division of Maternal and Child Health Title V funds
- U.S. Environmental Protection Agency
- Early intervention
- U.S. Department of Housing and Urban Development
- Adult Blood Lead and Epidemiology Surveillance (ABLES)[8]
- Housing Finance Agency
- Local funds

4. Medicaid Reimbursement for Services

In the advent of the Affordable Care Act, consumers and providers might anticipate access to and coverage of essential health services such as case management and environmental investigations by a qualified health professional. And, under Medicaid's child health component, the Early Periodic Screening, Diagnosis, and Treatment program (EPSDT), states are required to provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines. Equally important, even though some services are covered under the Medicaid program, reimbursement rates by Medicaid are too low and administrative requirements of participation too burdensome to justify the effort of pursuing this option.

Overall, programs are less likely to receive reimbursement for case management than for environmental investigations and local programs are less likely than states to be reimbursed by Medicaid for any program activities. No programs reported any reimbursement from private insurance.

Table 5: Medicaid Reimbursement for Services Among All Responding Programs

	Environmental Investigations	Case Management
State (n=22)	50%	32%
Local (n=9)	33%	11%

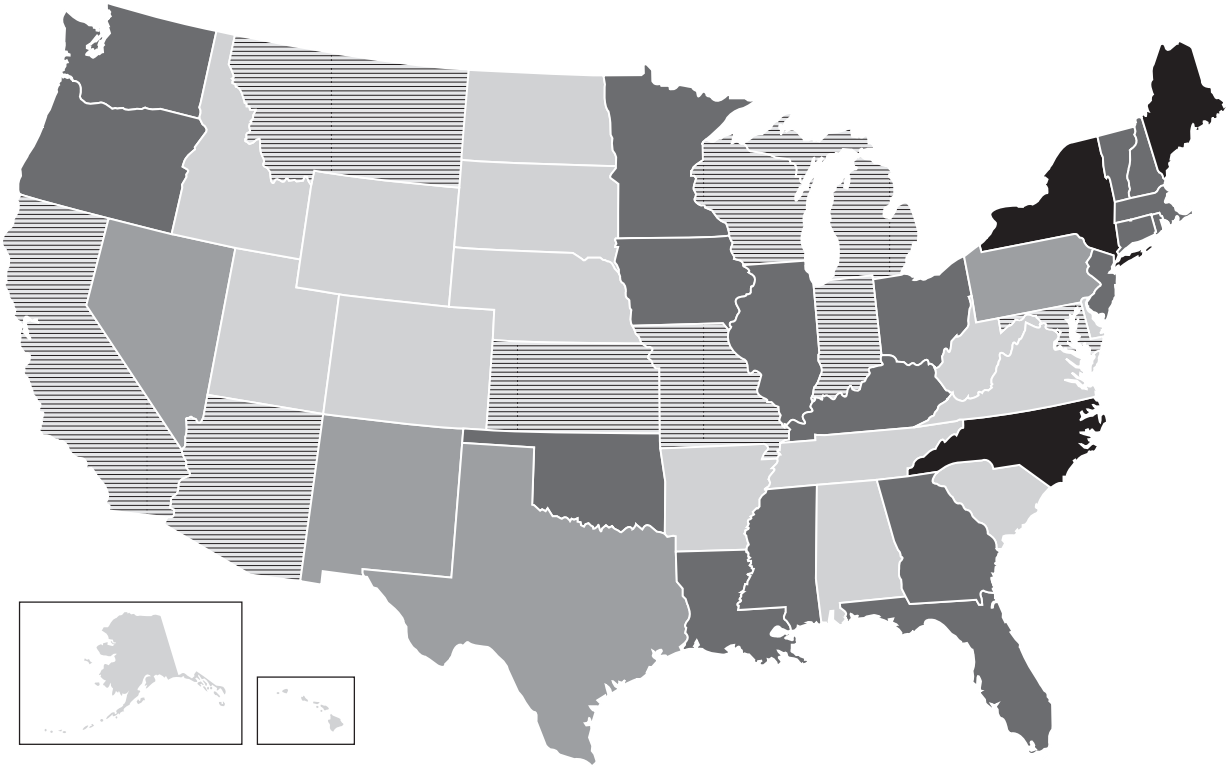
Conclusion

Our survey clearly demonstrates how the slashing of CDC's budget for Healthy Homes and Childhood Lead Poisoning Prevention Programs in FY12 has reverberated across the country, forcing state and local health departments to cut well regarded and effective services that are essential to public health. In most states, alternative sources of funding for essential personnel and the services they provided are not forthcoming. To accommodate the reduction in federal support, state and local programs have had to reduce program scope, reversing decades of progress toward the elimination of lead poisoning as a hazard for our most vulnerable populations.

[7] *Note that this program has been reduced from $0.812 million to zero in the FY14 budget.*

[8] *Note that this program has been reduced from $35 million to $26 million in the FY13 budget.*

Appendix 1: Distribution of Responses to CLPPP Survey



- Response from sub/local program(s) only
- Response from state program only
- Response from state program AND sub/local program(s)
- No Response
- State Not Previously Funded

Appendix 2: Descriptions of Healthy Homes and Childhood Lead Poisoning Prevention Jobs

Environmental Health Professionals—staff who do the home investigations, enforcement, and oversee any remediation efforts.

Environmental Health Practitioners use specialized equipment to measure the levels of contaminants in air, water, and soil, as well as noise and radiation levels. Some also design solutions to reduce pollutants or assist in clean-up and remediation efforts. http://explorehealthcareers.org/en/Career/133/Environmental_Health_Practitioner

Case Managers—staff, usually nurses, who conduct primary prevention activities, test children for lead, communicate results, educate, follow up, and coordinate care.

Health Educators—staff who focus on prevention

Health educators teach people about behaviors that promote wellness. They develop programs and materials to encourage people to make healthy decisions. http://www.bls.gov/ooh/community-and-social-service/health-educators.htm

The purpose of health education is to positively influence the health behavior of individuals and communities as well as the living and working conditions that influence their health. http://www.aahperd.org/aahe/proDevelopment/employmentOpportunities.cfm

By focusing on prevention, health education reduces the financial and human costs that individuals, employers, medical facilities, insurance companies, and the nation would spend on medical treatment. http://www.mphprograms.org/publichealthresources/roleofhealtheducation.html

Support staff—staff that take care on administrative, clerical, and data entry responsibilities.

Program Coordinators—on-the-ground staff who educate, conduct trainings, and may inspect homes and do case management.

Surveillance staff—staff who review BLLs, compile statistics about testing rates, affected children and adults, report findings to CDC, etc.

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[i] *Centers for Disease Control and Prevention. CDC Response to Advisory Committee on Childhood Lead Poisoning Prevention Recommendations in "Low Level Lead Exposure Harms Children: A Renewed Call of Primary Prevention". Atlanta, GA; 2012. Accessed at http://www.cdc.gov/nceh/lead/ACCLPP/CDC_Response_Lead_Exposure_Recs.pdf.*

[ii] *Centers for Disease Control and Prevention. Preventing Lead Exposure in Young Children: A Housing-Based Approach to Primary Prevention of Lead Poisoning. Atlanta: CDC; 2004.*

[iii] *http://mchb.hrsa.gov/epsdt/overview.html*

Appendix 3: Survey Questions

Childhood Lead Poisoning Prevention Programs

1. Is your childhood lead poisoning prevention program still in existence?

Close date

2. When did your childhood lead poisoning prevention program close?

Impact on staffing

3. Have any staff been eliminated or shifted to another department?
   If you are operating under a CDC grant extension, please respond as if that funding has concluded.

Additional detail about impact on staffing

4. How many positions were eliminated?
5. How many positions were shifted to another department?
6. Which positions were eliminated or shifted to another department?

Program components

7. Have any program components been eliminated?
   If you are operating under a CDC grant extension, please respond as if that funding has concluded.

Additional detail about program components

8. Have your surveillance activities been eliminated?
   Will your state continue to provide blood lead data to CDC? If so, who will provide it to CDC? If not, when did you stop?
9. Have your case management activities been eliminated?
   Approximately how many children will no longer receive case management services per year?
10. Have your environmental investigation activities been eliminated?
    Approximately how many investigations will no longer take place per year?
11. Have your primary prevention activities been eliminated?
    What primary prevention activities will be eliminated?
12. Have your blood lead screening activities been eliminated?
    If statistics exist, is there a change in the number of children tested for lead from 2011 to 2012?
13. Have your RRP training activities been eliminated?
    Approximately how many workers will no longer receive training from you?
14. Have your education/outreach activities to professionals been eliminated (e.g., outreach to medical professionals, realtors, property managers)?
    Approximately how many medical professionals, realtors/property managers, and other professionals will not receive educational presentations/materials?
15. Have your education/outreach activities to the general public been eliminated (e.g., outreach to families, pregnant women, community members)?
    How many families, pregnant women, and community members will not receive educational presentations/materials?
16. What other resources has the community lost?

Program component funding

17. Are any of your program components that were funded by the CDC being funded by other agencies or other sources?
18. You indicated that all or part of your program was being funded by another agency or funding source.
    Which agency or what other funding source is supporting one or more of your program components?

19. Which components of your program are currently funded?
20. When will that funding expire?

Reimbursement

21. Does Medicaid reimburse you for case management?
22. Does Medicaid reimburse you for environmental investigations?
23. Does private insurance reimburse you for case management?
24. Does private insurance reimburse you for environmental investigations?

Services to children

25. What services does your agency provide for children with blood lead levels between 5–9?

Information about your state

26. In what state does your program reside?
27. Please indicate your agreement with this statement: *You have my permission to specifically reference our state in the final report.*

Closing Thoughts

28. Whom do you represent?
29. Do you have any additional comments?